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Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS

Reinvigorating the AIDS response to catalyse sustainable development and United Nations reform

Report of the Secretary-General

Summary

Bold global commitments, shared financial responsibility and a people-centred approach based on the principles of equity have yielded shared success in the AIDS response. The 90-90-90 initiative has guided a dramatic expansion of antiretroviral treatment and greatly reduced AIDS-related deaths, while also contributing to a reduction in new HIV infections. A global plan to eliminate mother-to-child transmission of HIV has more than halved the number of new HIV infections among children. The AIDS response has made an important contribution to the demographic dividend of Africa, its recent economic growth and the emerging vision of Africa as a continent of hope, promise and vast potential.

Global optimism has fuelled the highest ambition within the 2030 Agenda for Sustainable Development: ending the AIDS epidemic by 2030. A fast-track response to reach this target has been agreed by the United Nations General Assembly within the 2016 Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. Achieving our aims on AIDS is interlinked with and embedded within the broader 2030 Agenda: both are grounded in equity, human rights and a promise to leave no one behind.

During my first months as Secretary-General, I have called on the international system to get back to basics: to put greater focus on building more resilient societies by putting respect for human rights at the centre of national and international policy, by reducing disenfranchisement and marginalization and by empowering women and girls. I have also called on the United Nations development system to increase the pace of reform — to become more nimble, efficient and effective. The AIDS response is a bellwether for both agendas: sustainable development and United Nations reform.

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Nevertheless, with less than four years remaining before fast-track milestones for 2020 must be achieved, there is a danger of optimism devolving into complacency. Global commitments are not being consistently translated into additional investment and action on the ground. Financing for the response has flatlined and progress on reducing new HIV infections among adults has stalled.

Gaps in the delivery of HIV prevention, testing and treatment services are largest in the populations that need them most. Girls and women are still bearing the brunt of the AIDS epidemic. Key populations, including sex workers, people who inject drugs, transgender people, prisoners and gay men and other men who have sex with men, remain at much higher risk of HIV infection. More than 10 million additional people living with HIV must access treatment by 2020; most of them are unaware of their HIV status. The rising number of people forcibly displaced by humanitarian crises is making disruptions of life-saving HIV treatment more common. Food insecurity in southern Africa and the hunger crises in the Horn of Africa and South Sudan increase vulnerability, especially among women and girls.

The epidemic is not over but, with an additional collective push, it can be. Building on the successful replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, an additional investment of roughly half a United States dollar per person per year globally can maintain momentum against AIDS. These resources must be invested wisely, using a location-population approach across the human life cycle to address the unique sets of challenges faced by individuals, villages, cities, countries and regions.

Ending AIDS also requires progress across the entire spectrum of rights: civil, cultural, economic, political, social, sexual and reproductive. Closing gaps in service coverage requires intensified efforts to reach and empower women and girls and enhance their agency, and more consistent efforts by Member States to work with civil society to ensure that people living with, at risk of or affected by HIV know their rights and have access to justice and legal services to prevent and challenge violations of human rights.

The greatest achievements of the global AIDS response thus far were forged by open dialogue, broad consensus, community-led activism, shared investment, innovation and joint action. These formulas for success can overcome the biggest barriers and fill remaining gaps. Engagement of civil society is key. Member States should respond to the call of the Joint United Nations Programme on HIV/AIDS (UNAIDS) for a grand prevention coalition that stimulates action across the five pillars of combination HIV prevention: comprehensive services for young women and adolescent girls and their male partners in high-prevalence locations; evidence-informed and human rights-based prevention programmes for key populations; strengthened national condom programmes; voluntary medical male circumcision in priority countries; and pre-exposure prophylaxis for population groups at higher risk of HIV infection. All national AIDS programmes require a strong community empowerment element and specific efforts to address legal and policy barriers. Strengthened accountability mechanisms are needed to stimulate greater action on gender inequality and gender-based violence.

Adoption of the latest evidence-informed approaches to HIV testing and treatment is critical to maintaining momentum towards 90-90-90 and 30 million people accessing antiretroviral therapy by 2020. Immediate steps should be taken for the training and deployment of 2 million new community health workers, rapid scale-up of community-based testing models, rapid diagnostic testing, HIV self-testing and partner notification and massive expansion of the availability of routine viral load monitoring. Scientific research, including the development of innovative HIV prevention tools, simpler and more effective medicines, a vaccine and a cure, requires unwavering investment.

UNAIDS has a critical role to play. Its unique model should be refined and reinforced so that it can continue to guide the global agenda, to support countries as they adopt fast-track approaches and to remain a pathfinder for United Nations reform.

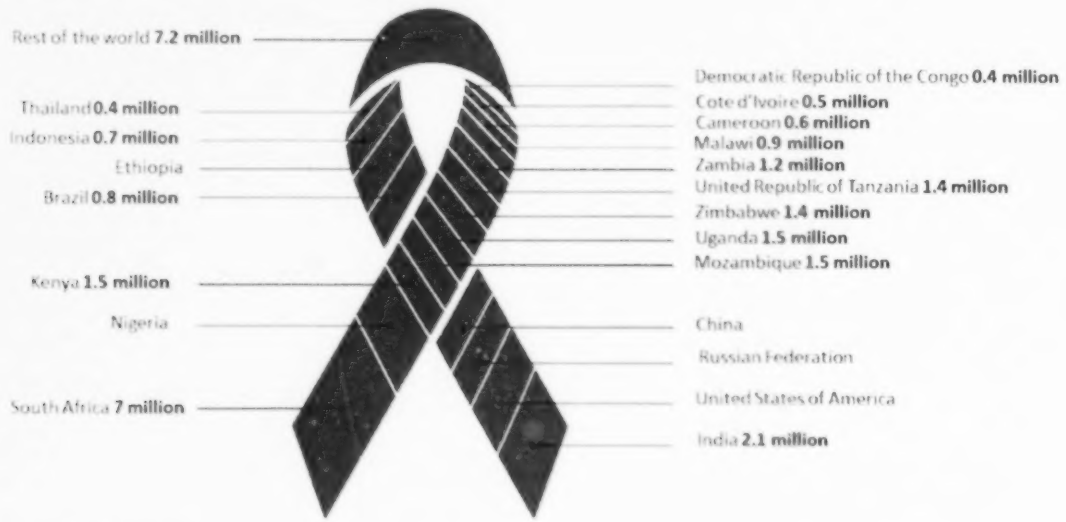
Hard-fought gains must not be lost. An international architecture that has stimulated leadership, provided direction, mobilized unprecedented levels of financial resources and saved millions of lives must not be taken for granted. Closing the investment gap of $7 billion per year and ensuring that financial resources are wisely used will avert tens of millions of new HIV infections and AIDS-related deaths, a return on investment that is nothing short of priceless.

I. Shared successes

1. After achieving the Millennium Development Goal to reverse the AIDS epidemic and reaching 15 million people with life-saving treatment by 2015, global optimism has fuelled the highest ambition: ending the epidemic by 2030. This target sits squarely within the 2030 Agenda for Sustainable Development and its global commitment to leave no one behind. A fast-track strategy to reach the end of AIDS anchors the Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030,[1] agreed by the General Assembly on 7 June 2016. That Declaration builds upon the foundation of the 2030 Agenda for Sustainable Development and contains a comprehensive set of fast-track targets.

2. Nevertheless, AIDS is far from over. Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates for 2015 show that there were 2.1 million [1.8 million-2.4 million][2] new HIV infections worldwide, 1.1 million [940,000-1.3 million] AIDS-related deaths and 36.7 million [34.0 million-39.8 million] people living with HIV. About 80 per cent of people living with HIV live in 20 countries (see figure I).

Figure I
36.7 million people living with HIV, worldwide, 2015



Source: UNAIDS 2016 estimates.
Note: Estimates for several countries were unavailable at the time of publication.

[1] General Assembly resolution 70/266.
[2] Square brackets denote uncertainty bounds around estimates to indicate the rage within which the true value lies.

90-90-90: a foundation for HIV testing and treatment action

3. The UNAIDS 90-90-90 target framework[3] serves as a foundation for action across a range of diverse stakeholders. Scientific evidence has been translated into global guidance on HIV testing and treatment aimed at greatly expanding access to testing for all people living with HIV so that they know their status as soon as possible after infection and are then immediately offered antiretroviral therapy. This approach not only greatly reduces AIDS-related deaths, but also helps prevent HIV infections. Newly available results from population-based HIV impact assessments conducted in Malawi, Zambia and Zimbabwe show that a high percentage of people who start treatment achieve viral suppression.[4] These results confirm that high-quality antiretroviral therapy is being delivered across continents and country income levels.

4. Rapid and sustained scale-up of HIV treatment is one of the greatest successes of global public health. The number of people living with HIV accessing antiretroviral therapy has increased by an order of magnitude since 2005, reaching 18.2 million [16.1 million-19.0 million] globally in mid-2016. AIDS-related deaths plummeted by 45 per cent, from a peak of 2 million [1.7 million-2.3 million] in 2005 to 1.1 million [940,000-1.3 million] in 2015 (see figure II). The global target of 30 million people accessing treatment by 2020 and the global milestone of fewer than 500,000 AIDS-related deaths a year are within reach.

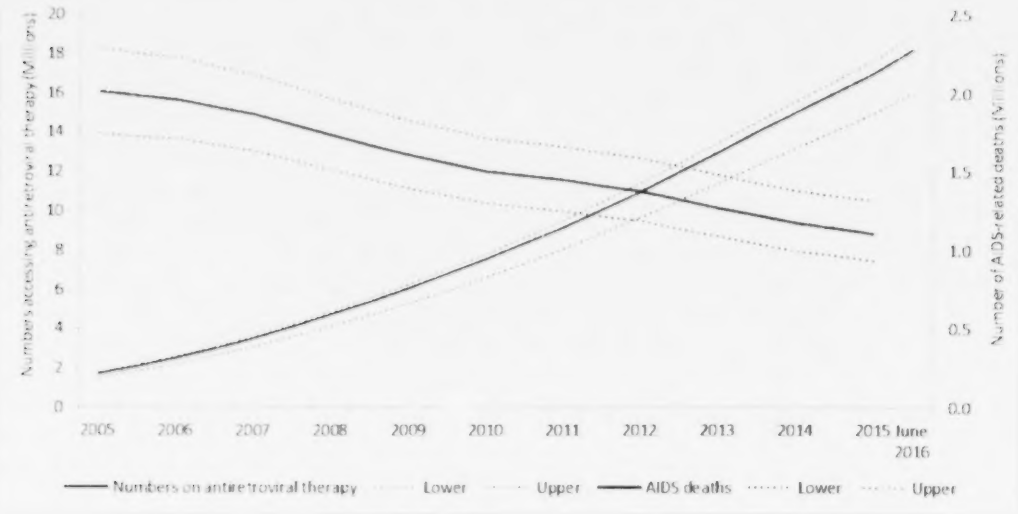
5. Nevertheless, the limited headway made on the first "90" threatens to slow progress across the continuum of HIV testing and treatment services. At the end of 2015, just 60 per cent [56-65 per cent] of people living with HIV knew their HIV status. Innovative tools and strategies, such as community-based HIV testing models, HIV self-testing and viral load testing, are underutilized.

[3] The 90-90-90 targets, launched by UNAIDS at the twentieth International AIDS Conference, held in 2014, have focused global efforts on a set of measurable targets to be achieved by 2020: 90 per cent of people living with HIV know their HIV status, 90 per cent of people who know their HIV-positive status are accessing treatment and 90 per cent of people accessing treatment have suppressed viral loads.

[4] United States Centers for Disease Control and Prevention, "New population-based HIV impact assessments survey data show critical progress towards global HIV targets". Available from www.cdc.gov/globalhivtb/who-we-are/events/world-aids-day/phia-surveys.html.

Figure II

Number of people accessing antiretroviral therapy and number of AIDS-related deaths worldwide, 2005-2016



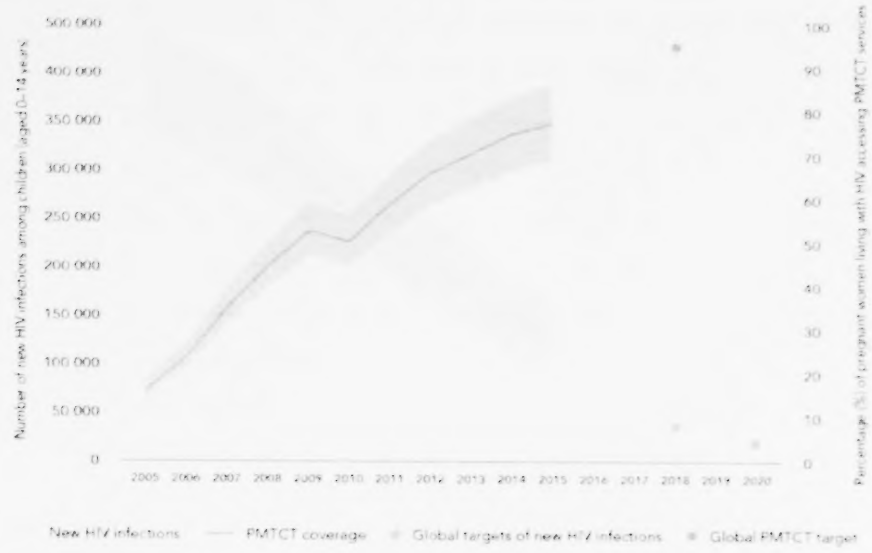
Source: UNAIDS estimates from "Get on the fast-track: the life-cycle approach to HIV" (Geneva, UNAIDS, 2016).

Eliminating new HIV infections among children

6. From 2011 to 2015, the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive galvanized global political will and national action. As a result, the number of new HIV infections among children aged 0-14 years declined by 56 per cent from 2009 to 2015 (see figure III). Coverage of services to prevent mother-to-child transmission of HIV increased dramatically, from 36 per cent [32-40 per cent] in 2010 to 77 per cent [69-86 per cent] in 2015. In addition, the number of children aged 0-14 years on antiretroviral therapy nearly tripled, from around 357,000 children in 2009 to 910,000 [801,000-947,000] children by mid-2016, nearly halving the number of AIDS-related deaths. These gains have inspired a life-cycle approach with the goal of all children starting life HIV-free and remaining HIV-free from birth to adulthood.

Figure III

New HIV infections among children (aged 0-14 years) and percentage of pregnant women living with HIV receiving antiretroviral medicine (either prophylaxis or lifelong therapy) to prevent mother-to-child transmission, worldwide, 2005-2015



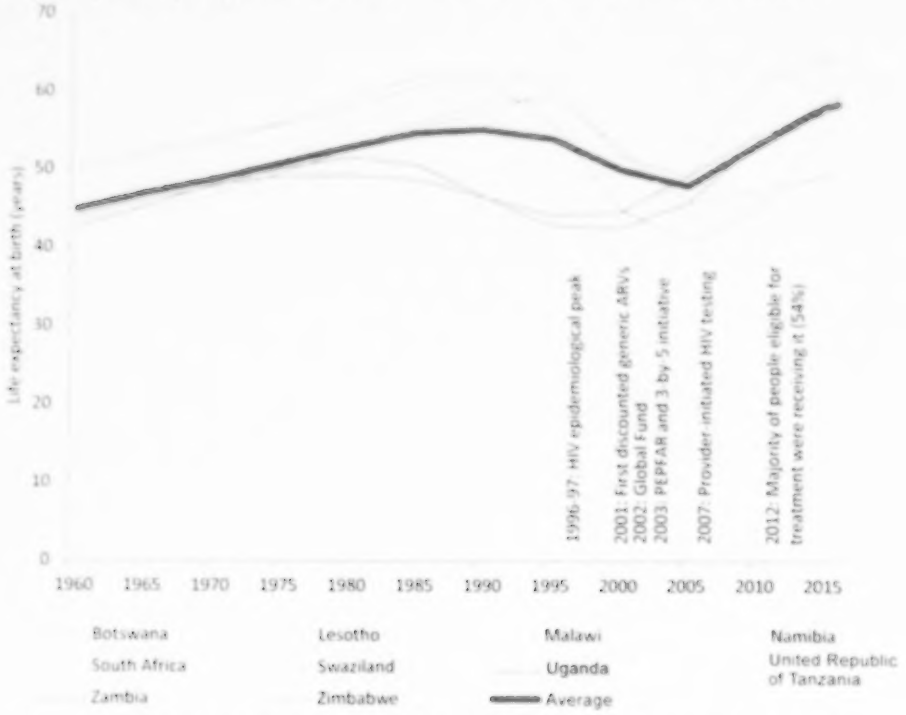
Source: UNAIDS 2016 estimates.
Abbreviation: PMTCT, prevention of mother-to-child transmission.

Global AIDS response: an investment in impact and development

7. The AIDS response appears to be contributing to the demographic dividend of and recent economic growth in Africa. In the 1990s and early 2000s, as AIDS-related deaths mounted in the 10 hardest-hit countries of East and Southern Africa, life expectancy declined from 55.0 years in 1990 to 48.9 years in 2006. This population-level impact reversed after antiretroviral therapy became widely available. Life expectancy steadily rose, reaching 58.4 years in 2015 (see figure IV).

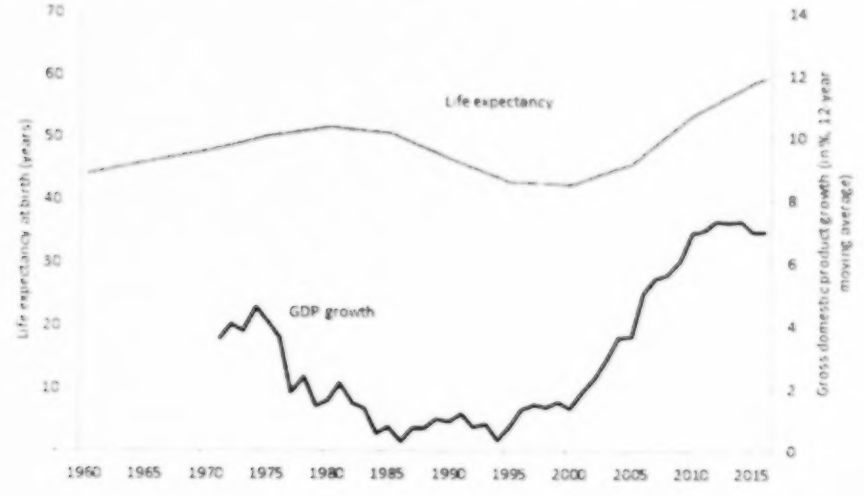
8. Changes in life expectancy and changes in economic growth across sub-Saharan Africa show a positive correlation — a relationship that is particularly strong for some individual countries, such as Zambia (see figure V). The tangible progress against AIDS has contributed to the vision of Africa as a continent of hope, promise and vast potential. Inclusive and sustainable development, guided by the 2030 Agenda and by Agenda 2063, developed by the African Union, is the surest path to durable peace and stability. These agendas require significant increases in political will and investment, both domestically and internationally.

Figure IV
Life expectancy for 10 countries in East and Southern Africa, 1960-2016



Source: UNAIDS analysis of data from United Nations Department of Economic and Social Affairs, Population Division, World Population Prospects: 2015 revision.
Abbreviations: ARV, antiretroviral; PEPFAR, President's Emergency Plan for AIDS Relief.

Figure V
Life expectancy and economic growth rates, Zambia, 1960-2016



Sources: 2017 UNAIDS analysis of economic data from the World Bank and population data from United Nations Department of Economic and Social Affairs, Population Division, World *Population Prospects: 2015 Revision*.

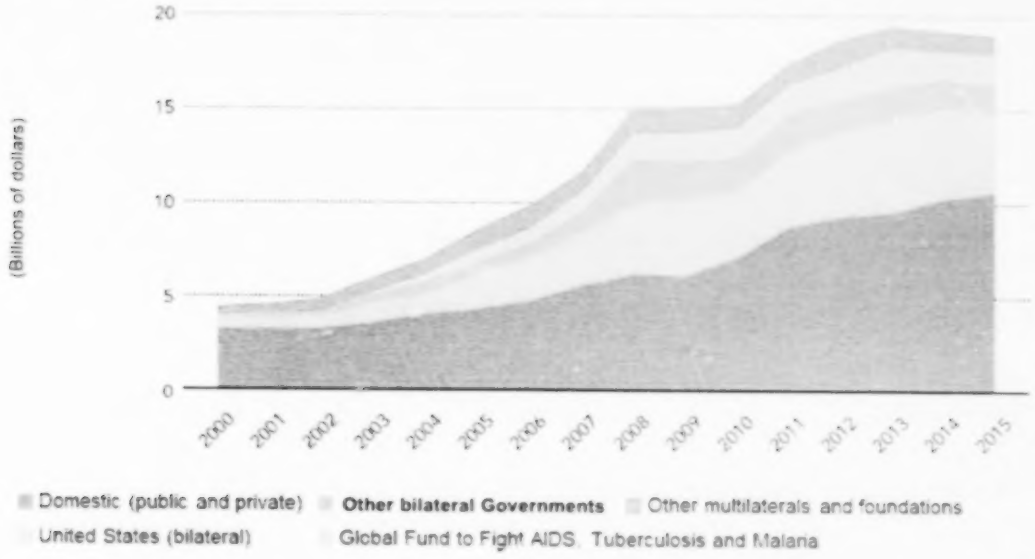
Increasing and accelerating shared investment

9. In the early years of the AIDS response, acceleration of shared investment was largely dependent on bilateral and multilateral aid. In more recent years, domestic investment has climbed steadily and now accounts for nearly 60 per cent of all resources for HIV in low- and middle-income countries. Middle-income countries such as Brazil, China, India, South Africa and Thailand now fund the vast majority of their AIDS-related services. This shared financial responsibility has been a key driver of progress and remains critical to sustainability within a changing global context.

10. The 2016 Political Declaration on HIV and AIDS includes a commitment to adequately invest in a fast-track approach: $26 billion in developing countries by 2020, including one quarter of total investment for HIV prevention and 6 per cent of total investment for social enablers. While domestic investment has increased, reductions in donor spending, exchange rate fluctuations and delays in expected donor disbursements have seen total annual investment in low- and middle-income countries decrease slightly in recent years to $19.0 billion in 2015 (see figure VI).

Figure VI

Investments in the AIDS responses of low- and middle-income countries, by source of funding, 2000-2015



Sources: UNAIDS estimates, June 2016; Jennifer Kates and others, "Financing the response to AIDS in low- and middle-income countries" (The Henry J. Kaiser Family Foundation and UNAIDS, July 2016); and Organization for Economic Cooperation and Development, Common Reporting Standard.

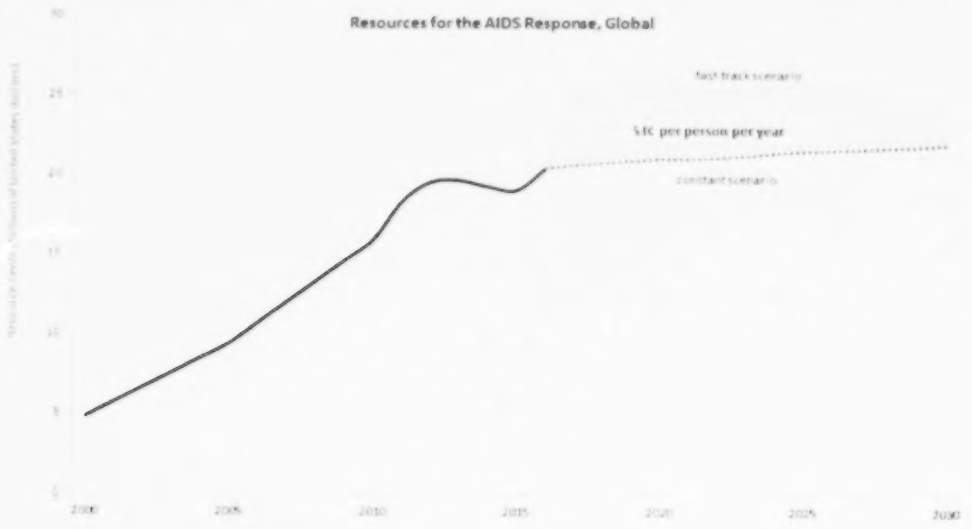
11. The successful replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria in September 2016 has been an important step in the right direction. Additional investment by all countries across the AIDS response system is critical to closing the $7 billion investment gap — an amount that translates to an additional $0.53 [$0.37-$0.93] per person per year globally from 2016 to 2030[5] (see

[5] Discounted rate r=3per cent, with the lower and upper bounds being whether the improvement in efficiency and unit costs of the AIDS response applies only to the fast-track scenario or to both the constant and the fast-track scenarios.

figure VII). This small per capita increase in investment will generate significant returns: an additional 21.7 million HIV infections and 8.8 million AIDS-related deaths would be averted between 2016 and 2030 (see figure VIII). It will also generate additional economic benefits of $63.30 per person, or $8.04 [$4.56-11.52] for each $1.00 spent.[a] This 8-to-1 return on investment includes the value of better health and reduced mortality.

Figure VII

Additional investment (per person per year) needed to achieve global targets, 2016-2030

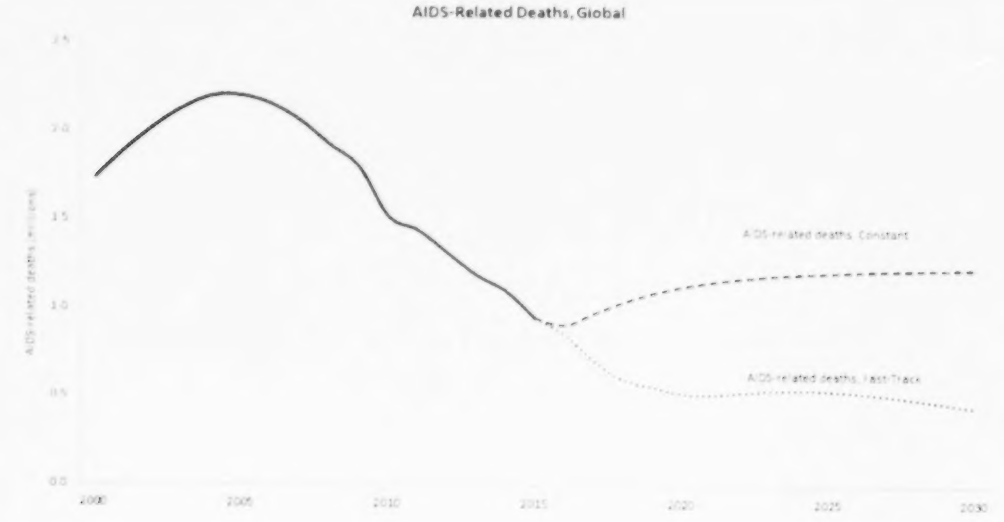


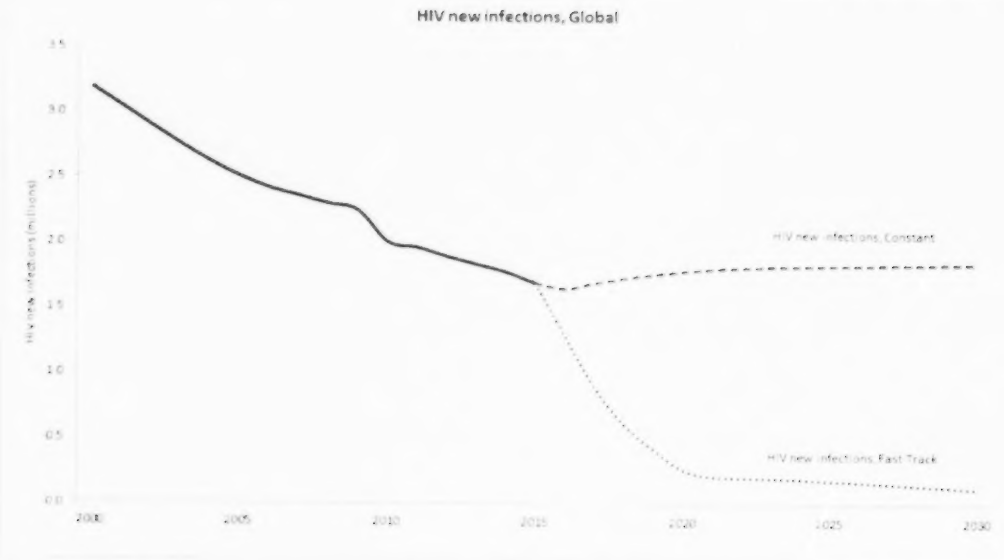
Source: Erik Lamontagne and others, "The economic returns of ending the AIDS epidemic by 2030".

[a] Erik Lamontagne and others, "The economic returns of ending the AIDS epidemic by 2030" (2017), in press.

Figure VIII

New HIV infections and AIDS-related deaths that can be averted through a fast-track approach, 2016-2030





Source: Erik Lamontagne and others, "The economic returns of ending the AIDS epidemic by 2030".

II. Leaving no one behind

12. Achieving the strategic milestones and targets within the 2016 Political Declaration will not be possible if the status quo is maintained. AIDS is far from over and stubborn challenges stand in the way. Our efforts to close gaps must ensure that no one is left behind — by empowering people who have been pushed to the margins of society, protecting human rights and delivering services to all in need.

Five pillars for reaching fewer than 500,000 new HIV infections by 2020

13. While there has been steady progress in the reduction of HIV infections among children, declines in new infections among adults have slowed. Since 2010, the annual number of new HIV infections among adults (15+) has remained essentially static at an estimated 1.9 million [1.7 million-2.2 million in 2015] (see figure IX). Trends among key populations at higher risk of HIV infection are even more worrisome. The available data suggest that new HIV infections among people who inject drugs climbed by a third and new infections among men who have sex with men rose by about 12 per cent globally from 2011 to 2015. New infections among sex workers and transgender people remained stable over the same time period (see figure X).

Figure IX
New HIV infections among adults (aged 15 years and older), worldwide, 2000-2015

Source: UNAIDS 2016 estimates.

Figure X
Trends in new HIV infections among key populations, worldwide, 2011-2015

Source: UNAIDS special analysis, 2016.
Note: Data on transgender people are from the Asia-Pacific and Latin America and Caribbean regions only.

14. Epidemiological models suggest that a balanced approach, including high coverage of a combination of high-impact HIV prevention interventions and continued scale up of treatment, is needed.[7] The experiences of countries show that intensification of HIV prevention efforts yields results. In South Africa and Zimbabwe, increased condom use has contributed to reductions in HIV incidence.[8,9] Similarly, decriminalization of the use and possession of small quantities of drugs in Czechia, combined with relatively high coverage of needle and syringe programmes and opioid substitution therapy, have been credited with the country's remarkably low rates of HIV among people who inject drugs.[10]

15. The toolkit for HIV prevention has expanded in recent years. Adopting new technologies can help deliver fast-track results. In the United States of America, San Francisco's aggressive addition of pre-exposure prophylaxis (PrEP) to a comprehensive city AIDS response coincided with a 29 per cent reduction in new infections from 2012 to 2014.[11]

[7] J. Stover and other, "What is required to end the AIDS epidemic as a public health threat by 2030? The cost and impact of the fast-track approach", *PLoS ONE* (9 May 2016).
[8] D. Halperin and others, "A surprising prevention success: why did the HIV epidemic decline in Zimbabwe?", *PLoS Medicine*, (8 February 2011).
[9] L. Johnson and others, "The effect of changes in condom usage and antiretroviral treatment coverage on human immunodeficiency virus incidence in South Africa: a model-based analysis", *Journal of the Royal Society Interface* (2012).
[10] Ioanne Csete, *A Balancing Act: Policymaking on Illicit drugs in the Czech Republic* (New York, Open Society Foundations, 2012).
[11] San Francisco Department of Public Health, Population Health Division, HIV Epidemiology Section, *HIV Epidemiology Annual Report 2014* (August 2015).

16. Getting on track to reducing the number of new infections to 500,000 by 2020 requires more intensive focus on HIV prevention delivered through a people-centred, combination approach focused on five pillars:

(a) Combination prevention, including comprehensive sexuality education, economic empowerment and access to sexual and reproductive health services for young women and adolescent girls and their male partners in high-prevalence locations;

(b) Evidence-informed and human rights-based prevention programmes for key populations, including dedicated services and community mobilization and empowerment;

(c) Strengthened national condom programmes, including procurement, distribution, social marketing, private-sector sales and demand creation;

(d) Voluntary medical male circumcision in priority countries that have high levels of HIV prevalence and low levels of male circumcision, as part of the wider provision of sexual and reproductive health services for boys and men;

(e) PrEP for population groups at higher risk of HIV infection.

17. In recognition of this, the 2016 Political Declaration is the first such declaration by the General Assembly to include programmatic coverage targets for key prevention interventions. Nevertheless, in many countries these global targets have yet to be translated into national targets. Large programmatic gaps persist and sufficient funding for prevention programmes remains elusive.

Young women and adolescent girls and their male partners

18. The 2016 Political Declaration includes a commitment to reduce the number of new HIV infections among adolescent girls and young women to below 100,000 per year by 2020. Between 2010 and 2015, new infections among females aged 15-24 years declined by 6 per cent, from 420,000 [360,000-480,000] to 390,000 [330,000-460,000]. Hitting the target will require a 74 per cent reduction between 2015 and 2020 (see figure XI). Greater progress on gender equality and the empowerment of women and girls, as called for in Sustainable Development Goal 5, will be critical. Programming efforts must recognize the complexity of the everyday lives of girls and women as they mature and grow, and build the response around their needs.

Figure XI
New HIV infections among young women (aged 15-24 years), worldwide, 2005-2015

Source: UNAIDS 2016 estimates.

19. Structural interventions can address the drivers of heightened HIV risk among young women and girls. For example, the removal of parental and spousal consent requirements for access to HIV and sexual and reproductive health services can greatly increase service uptake. Passage of laws that foster the wide dissemination of objective comprehensive sexuality information improve knowledge of not only what protects or damages sexual health, but also where and how to seek further information, counselling and treatment.

Key populations

20. Key populations remain at much higher risk of HIV infection. Recent studies suggest that people who inject drugs are 24 times more likely to acquire HIV than adults in the general population, sex workers are 10 times more likely to acquire HIV and men who have sex with men are 24 times more likely to acquire HIV. In addition, transgender people and prisoners are 49 times and 5 times more likely, respectively, to be living with HIV than adults in the general population.

21. Needle and syringe programmes, opioid substitution therapy and other effective tools and strategies for improving the health and lives of people who inject drugs are well known, but their availability is limited in many countries. Young people within key populations face particular HIV risks, often as a result of lower knowledge of risks or lower ability to mitigate those risks compared with their older, more experienced counterparts. In addition, rising domestic investment in AIDS responses appears to be leaving key populations behind. On average, domestic funding accounts for only 12 per cent of spending on prevention programmes for men who have sex with men. The percentage of total prevention spending that comes from domestic sources is similarly low for sex workers (20 per cent) and people who inject drugs (25 per cent).

Condoms

22. Condoms are cost-effective tools for preventing HIV, other sexually transmitted infections and unintended pregnancies. The estimated annual condom need in 47 countries in sub-Saharan Africa in 2015 was 6 billion male condoms. Nevertheless, only an estimated 2.7 billion condoms were distributed in 2015, indicating that more than half of the condom need was not met.

23. Insufficient condom availability in sub-Saharan Africa is reflected in overall low levels of condom use. In 23 of 25 countries in the region with available data, less than 50 per cent of men with multiple sexual partners reported using a condom the last time they had sex, and in 19 sub-Saharan African countries, less than 60 per cent of young women with multiple partners reported condom use.

24. Condom use is also low among key populations. Only 3 of 104 countries with available data reported greater than 90 per cent condom use among men who have sex with men the last time they had sexual intercourse. Low condom use among men who have sex with men in high-income countries — where antiretroviral therapy coverage and condom availability are high — is consistent with evidence of complacency or condom fatigue.

Voluntary medical male circumcision

25. Voluntary medical male circumcision is a cost-effective, one-time intervention that provides lifelong partial protection against female-to-male HIV transmission. Since 2007, tremendous efforts have been made to scale up voluntary medical male circumcision in 14 priority countries in East and Southern Africa that have high levels of HIV prevalence and low levels of male circumcision. Nevertheless, following years of rapid increase, the annual number of circumcisions performed in

8 of the 14 priority countries declined in 2015. Reaching the 2020 target of 25 million additional young men in high-prevalence settings circumcised will require a doubling of the annual number of circumcisions performed in the 14 priority countries.

Pre-exposure prophylaxis

26. PrEP is the latest addition to combination prevention options for people at high risk of HIV infection. PrEP empowers individuals to discreetly take control of their own HIV risk through daily doses of antiretroviral medicines. A small but growing number of national health systems have approved PrEP for use; scale and coverage remain limited. In mid-2016, an estimated 60,000 people were enrolled in PrEP, the majority of whom were in the United States. Considerable additional effort will be needed to reach the global target of 3 million people at substantial risk of HIV infection accessing PrEP by 2020.

A diversity of epidemics requires a location-population approach across the life cycle

27. Each region of the world has a unique set of challenges to address. East and Southern Africa have only 6.2 per cent of the world's population but are home to half of the world's people living with HIV. In West and Central Africa, structural barriers, weak supply chains and conflict have stymied progress against AIDS. The Asia and Pacific region has the second highest number of people living with HIV; its HIV epidemic is concentrated among key populations and their intimate partners. The Latin America and Caribbean region has made strong progress towards the elimination of mother-to-child transmission, while rates of new HIV infections among gay men and other men who have sex with men remain high in urban areas. The Middle East and North Africa is the region with the lowest prevalence of HIV, but new infections increased by 4 per cent between 2010 and 2015. Eastern Europe and Central Asia are the only regions where the HIV epidemic continues to grow rapidly, with people who inject drugs accounting for half of new HIV infections. In Western and Central Europe, long-term high coverage of harm reduction programmes has reduced the number of new infections among people who inject drugs, but there are indications that levels of condom use have not improved among gay men and other men who have sex with men. In North America, a major challenge is the continued disproportionate impact of HIV on gay men and other men who have sex with men, people who inject drugs, African-American men and women, and migrants originating in high-endemic areas.

28. Acknowledgement of the need for intensified regional action led to the inclusion in the 2016 Political Declaration of regional targets for reductions in new HIV infections and for increases in the number of people accessing treatment. Addressing the diversity of epidemics in regions, countries, cities and communities requires a location-population approach that focuses HIV responses on evidence-informed, high-impact services for the geographic areas and populations in greatest need. Many countries now have the ability to monitor their HIV epidemic at the subnational level. Use of these data can improve the efficiency and effectiveness of their AIDS responses.

29. A life-cycle approach can be used to better address the complex dynamics of the HIV epidemic. Innovations in data collection reveal how the risks of infection, the challenges of accessing services and the solutions to these challenges change at different stages of life. The risk of infection among children is minimized when readily available diagnostics and antiretroviral medicines are used in a timely

manner. The transition from childhood to adulthood is particularly unique, with adolescent girls at considerably higher risk of HIV infection, especially in high-prevalence settings. Adolescence is also a dangerous time for those already living with HIV; treatment adherence is low and treatment failure is high in this age group. As life progresses into adulthood, the proportion of people newly infected with HIV worldwide who are men grows steadily. There has also been an increase in new HIV infections among older people, and the long-term complications of antiretroviral medications, lifestyle and age-related diseases create substantial health challenges for older people living with HIV.

III. AIDS and the 2030 Agenda

30. The 2016 Political Declaration sits squarely within the framework of the 2030 Agenda for Sustainable Development. The Declaration includes commitments to eliminate gender inequality; to promote, protect, respect and fulfil all human rights and dignity; to work towards achieving universal health coverage; and to ensure delivery of more integrated services for HIV, tuberculosis, viral hepatitis, sexually transmitted infections, cervical cancer and other non-communicable diseases, drug dependence, food and nutrition support, maternal, child and adolescent health, men's health, mental health and sexual and reproductive health. These commitments reinforce the holistic nature of the AIDS response and linkages across the 2030 Agenda.

Gender equality

31. Girls and women are still bearing the brunt of the AIDS epidemic. In sub-Saharan Africa, girls account for three out of four new HIV infections among those aged 15 to 19 years. Globally, AIDS remains a leading cause of death among women aged 15-29.[12] The heightened vulnerability of women and girls to HIV goes far beyond physiology: it is intricately linked to entrenched gender inequalities, harmful gender norms and social structures that limit women and girls from reaching their full potential. Health services, including sexual and reproductive health and HIV services, for adolescent girls and women are not yet universally available. A young girl forced to leave school to supplement her family's income is less likely to have the knowledge or power to protect herself from HIV. Research in Botswana and Swaziland found that women who lacked sufficient food were less likely to use condoms with non-regular partners, more likely to engage in transactional sex and more likely to report a lack of control in their sexual relationships.[13]

32. Experiences of physical and emotional intimate partner violence in settings with male controlling behaviour and HIV prevalence above 5 per cent have been strongly associated with HIV infection in women.[14] In some regions, women who experienced intimate partner violence were 1.5 times more likely to acquire HIV

[12] World Health Organization, "Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000-2015 (Geneva, 2016).

[13] Sheri Weiser and others, "Food insufficiency is associated with high-risk sexual behavior among women in Botswana and Swaziland", *PLoS Medicine*, vol. 4, No. 10 (23 October 2007).

[14] Dick Durevall and Annika Lindskog, "Intimate partner violence and HIV in ten sub-Saharan African countries: what do the demographic and health surveys tell us?", *The Lancet Global Health*, vol. 3, No. 1 (20 November 2014).

than women who had not experienced violence.[15] Some of the intimate partner violence experienced by young women occurs within the context of child marriage. A violation of fundamental human rights, child marriage can severely compromise a girl's development, result in early pregnancy and social isolation, interrupt her schooling and limit her opportunities for a career and vocational advancement.[16]

33. Studies have shown that increasing educational achievement among women and girls reduces a woman's personal risk of partner violence[17] and is linked to better sexual and reproductive health outcomes,[18] including lower rates of HIV infection.[19] Social protection measures such as cash transfers have been shown to empower young women, keep them in school and dramatically reduce economically driven sex. Cash transfers have been successfully used as an incentive for school attendance and safer sexual health, leading to a positive effect on HIV-associated outcomes.[20] In South Africa, a project's use of cash transfers nearly halved the percentage of girls aged 12-18 years engaging in economically driven sex, and further reductions were achieved by augmenting financial support with social support from parents and teachers.[21] Social protection provisions such as nutritional support also increase adherence to antiretroviral therapy. The 2016 Political Declaration encourages Member States to strengthen national social and child protection systems to ensure that, by 2020, 75 per cent of people living with, at risk of or affected by HIV who are in need benefit from HIV-sensitive social protection, including cash transfers.

Putting human rights at the centre of development and the AIDS response

34. The 2030 Agenda promises "peaceful, just and inclusive societies, which are free from fear and violence" and envisages "a world of universal respect" for "equality and non-discrimination" between and within countries. Maintaining momentum against AIDS is interlinked with the efforts to secure sustainable development and to improve global peace and security. To do so, we must get back to basics, building more resilient societies by putting respect for human rights at the centre of national and international policy, reducing disenfranchisement and marginalization and empowering women and girls.

35. In the 2016 Political Declaration, United Nations Member States committed to national AIDS strategies that empower people living with, at risk of or affected by

[15] World Health Organization, London School of Hygiene and Tropical Medicine, and South African Medical Research Council, *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence* (Geneva, 2013).

[16] United Nations Children's Fund data: monitoring the situation of children and women. Available from http://data.unicef.org/child-protection/child-marriage.html (accessed 6 July 2016).

[17] Lori Heise and Andreas Kotsadam, "Cross-national and multilevel correlates of partner violence: an analysis of data from population-based surveys", *The Lancet Global Health*, vol. 3, No. 6 (June 2015).

[18] United Nations Population Fund, *State of World Population 2013: Motherhood in Childhood Facing the Challenges of Adolescent Pregnancy* (New York, 2013).

[19] Jan-Walter De Neve and others, "Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment", *The Lancet Global Health*, vol. 3, No. 8 (August 2015).

[20] Jessica Taaffe and others, "The use of cash transfers for HIV prevention — are we there yet?", *African Journal of AIDS Research*, vol. 15, No. 1 (22 March 2016).

[21] Lucie Cluver and others, "Combination social protection for reducing HIV-risk behaviour amongst adolescents in South Africa", *Journal of Acquired Immune Deficiency Syndrome*, vol. 72, No. 1 (May 2016).

HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights. Many have followed through with effective measures: reviewing and revising legal, social and policy frameworks to support people living with HIV and key populations; eliminating travel restrictions; providing legal literacy and other legal education for affected people; expanding access to justice; offering programmes to eliminate stigma and discrimination in health-care settings; building the human rights competences for legislators, police, judges and health-care workers; and expanding community-led services.

36. Significant gaps exist, however. Punitive laws, policies and practices continue to deny access to effective services to the people who need them most. Among people living with HIV, one person in eight reports having been denied health care. Stigmatizing attitudes and outright discrimination on the part of health workers have been widely documented and found to constitute an important barrier to seeking, using and adhering to HIV prevention services and treatment, as well as disclosing HIV status. Overly broad criminalization of HIV non-disclosure, exposure or transmission deters people from seeking to know their own status or from accessing HIV services, including prevention services and commodities. By 2015, 72 countries had laws that specifically allowed for the criminalization of HIV. Prosecutions for HIV non-disclosure, potential or perceived exposure and/or unintentional transmission had been reported in 61 countries, an increase from at least 49 in 2014. As at September 2015, 35 countries, territories and areas had imposed some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status.

37. Anti-discrimination legislation exists in many countries, but enforcement of such laws is inconsistent. In 22 countries, more than one in five people living with HIV said they had been refused employment or a work opportunity because of their HIV status. In seven countries, almost half of people living with HIV reported they had lost a job or another source of income because of their HIV status; in another seven countries, that had been the case for at least 20 per cent of people living with HIV.[22]

38. Stigma, discrimination and criminalization of same-sex relationships, sex work, drug possession and drug use are day-to-day barriers to services in too many countries. For example, as at June 2016, same-sex sexual acts were illegal in 73 countries and five entities, and the death penalty could be applied for same-sex sexual acts in 13 countries.[23] Women in key populations face specific challenges and barriers, including violence and violations of their human rights. Consistent action on the empowerment of people living with or at risk of HIV is essential to truly leaving no one behind.

Integrating AIDS within the global health agenda

39. The response to HIV is intertwined with efforts to strengthen health systems, to expand access to sexual and reproductive health and family-planning services and to tackle a host of communicable and non-communicable diseases. Although major gains have been made in the response to tuberculosis, it remains among the most common causes of illness and death among people living with HIV. Weaknesses in health systems are continuing to result in missed opportunities to diagnose tuberculosis among people living with HIV: around 57 per cent of HIV-associated

[22] People Living With HIV Stigma Index surveys, 2008-2014.

[23] Aengus Carroll, "State-sponsored homophobia: a world survey of sexual orientation laws — criminalisation, protection and recognition", 11th ed. (Geneva: International Lesbian, Gay, Bisexual, Trans and Intersex Association, May 2016).

tuberculosis cases remained untreated in 2015. Barriers include inadequate linkages to care after diagnosis, poor tracking of people and loss to follow-up, and failure to reach the people most at risk of disease. Mounting cases of drug-resistant tuberculosis are threatening to slow progress. Among notified tuberculosis patients, HIV testing and the immediate offer of antiretroviral treatment among those found to be living with HIV need to be expanded. People living with HIV require rapid testing for tuberculosis and resistance to rifampicin, as well as tuberculosis preventative treatment and nutritional support.

40. Women living with HIV are at four to five times greater risk of developing cervical cancer.[24] This risk is linked to the human papillomavirus (HPV), a common infection among sexually active men and women that is difficult for women with compromised immune systems to clear. Minimizing deaths from cervical cancer requires a comprehensive approach. A key strategy is early vaccination of adolescent girls, before sexual exposure. HPV immunization programmes to date have been predominantly in high-income countries. Of the estimated 118 million women aimed to be reached by HPV immunization programmes conducted between June 2006 and October 2014, only 1 per cent were from low-income or lower-middle-income countries.[25] Linking cervical cancer screening and HIV services is a cost-effective approach. In Zambia, service integration expanded cervical cancer screening to more than 100,000 women (28 per cent of whom were living with HIV) over a period of five years.[26]

41. An estimated 10 million people who inject drugs have hepatitis C infection, and an estimated 82.4 per cent of people who inject drugs who are living with HIV are co-infected with the hepatitis C virus (see figure XII). Needle and syringe programmes effectively prevent both HIV and hepatitis C infections and avoid long and costly treatment. In eight countries in Eastern Europe and Central Asia, a tripling of needle and syringe programme coverage between 2005 and 2010 reduced risk behaviour and new infections.[27]

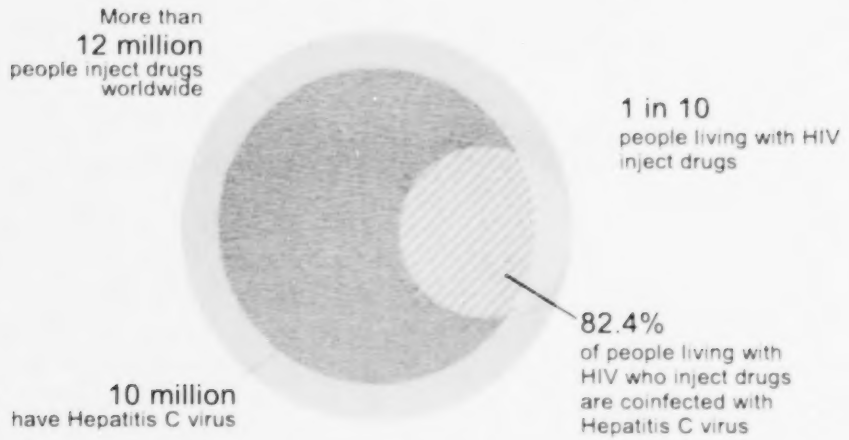
[24] Sheri Denslow and others, "Incidence and progression of cervical lesions in women with HIV: a systematic global review", *International Journal of STD & AIDS*, vol. 25 No. 3 (2014).

[25] Laia Bruni and others, "Global estimates of human papillomavirus vaccination coverage by region and income level: a pooled analysis", *The Lancet Global Health*, vol. 4, No. 7 (July 2016).

[26] Groesbeck Parham and others, "Implementation of cervical cancer prevention services for HIV-infected women in Zambia: measuring program effectiveness", *HIV Therapy*, vol. 4, No. 6 (November 2010).

[27] David Wilson and others, "The cost-effectiveness of needle-syringe exchange programs in Eastern Europe and Central Asia: costing, data synthesis, modeling and economics for eight case study countries", presentation at the nineteenth International AIDS Conference, held from 22 to 27 July 2012 in Washington, D.C.

Figure XII
HIV and hepatitis C virus coinfection, worldwide, 2014



Sources: UNAIDS estimates, 2015; World Health Organization, hepatitis fact sheets (2015); and Lucy Platt and others, "Prevalence and burden of HCV co-infection in people living with HIV: a global systematic review and meta-analysis", *The Lancet Infectious Diseases*, vol. 6, No. 7 (July 2016).

42. Community-based services are an important way to fill gaps and reach those who are unable to access traditional service providers or may not feel comfortable doing so. In recognition of this, the global commitment to people-centred systems for health in the 2016 Political Declaration includes a specific target to expand community-led service delivery to cover at least 30 per cent of all service delivery by 2030. Several recent good practices include leveraging community-based services within fast-track responses. The Sustainable East Africa Research on Community Health trial in Kenya and Uganda is combining HIV testing and treatment with the delivery of a range of primary health-care services. In many countries, the community-based provision of naloxone to people who use opioid drugs is proving to be a lifesaving public health measure. Recruitment, training and deployment of far greater numbers of community health workers are needed to bring community-based models to scale.

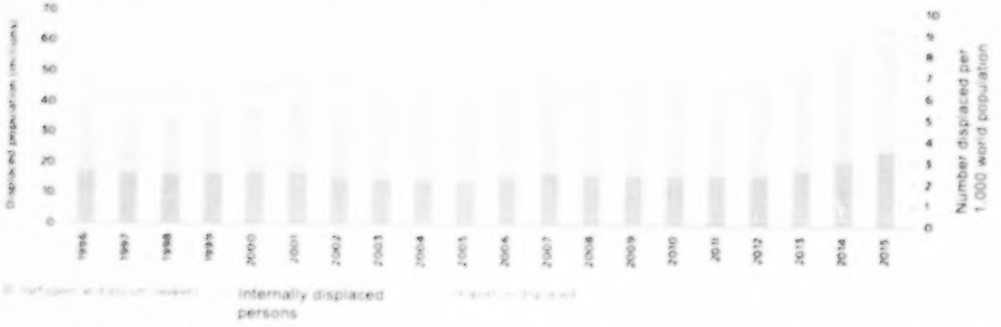
43. Medical research and development also requires continued investment. Recent progress towards a vaccine for HIV has stirred renewed hope for a breakthrough. There have also been exciting developments in the search for a cure, including approaches that target reservoirs of HIV within the gut and bone marrow. Funding for these endeavours has plateaued over the past few years.

Humanitarian emergencies

44. The number of people displaced by humanitarian emergencies is on the rise. In 2015, 65.3 million people had been forcibly displaced worldwide as a result of persecution, conflict, generalized violence or human rights violations, an increase of

more than 50 per cent in five years (see figure XIII).[28] During the same period, the number of people living with HIV on antiretroviral therapy nearly doubled. Together, these trends increase the likelihood that conflict will disrupt the delivery of life-saving HIV treatment. UNAIDS estimates that 1.6 million people living with HIV were affected by humanitarian emergencies in 2013, or 1 of every 22 people living with HIV.[29] More than 80 per cent of these people were in sub-Saharan Africa.

Figure XIII
Number of people and proportion of people forcibly displaced, 1996-2015



Source: Office of the United Nations High Commissioner for Refugees, *Global Trends: Forced Displacement in 2015* (Geneva, 2016).

45. High rates of sexual exploitation and violence within conflict and post-conflict environments create particular HIV risks, including lack of safe and accessible clinical care. Research consistently shows that violence against women and girls by partners and other civilians increases during periods of conflict.[30] Forced sex is associated with increased genital trauma, abrasions and coital injuries, which facilitate HIV transmission.[31] In addition, perpetrators of sexual violence are more likely to practise unprotected sex and have multiple sexual partners, increasing the probability that they have HIV or another sexually transmitted infection.[32] Social stigma and cultural taboos may prevent victims from seeking justice and medical services even when they are available. These patterns of violence against women and girls underscore the need for initiatives to respond explicitly to the full range of violence that women and girls experience in conflict and post-conflict settings, including its links to HIV.

46. The 2016 Political Declaration notes the increased vulnerabilities of displaced people and people affected by humanitarian emergencies and commits Member States to pursuing the continuity of HIV prevention, treatment, care and support and

[28] In 2014, when 59.4 million were displaced by these events, an additional 19.3 million people were displaced by natural disasters. Michelle Yonetani and others, "Global estimates 2015: people displaced by disasters" (Geneva, International Displacement Monitoring Centre, July 2015).

[29] UNAIDS background note on HIV in emergency contexts for the thirty-sixth meeting of the UNAIDS Programme Coordinating Board, held from 30 June to 2 July 2015 in Geneva.

[30] Lori Heise and Elizabeth McGrory, "Violence against women and girls, and HIV: report on a high-level consultation on the evidence and implications", (STRIVE Research Consortium, London School of Hygiene and Tropical Medicine, 2016).

[31] Alex de Waal and others, *HIV/AIDS, Security and Conflict: New Realities, New Responses* (New York, Social Science Research Council, 2009).

[32] Michael Westerhaus and others, "Framing HIV prevention discourse to encompass the complexities of war in northern Uganda", *American Journal of Public Health*, vol. 9, No. 7 (July 2007).

to providing a package of care for people living with HIV, tuberculosis and/or malaria in humanitarian emergencies and conflict settings, with a particular focus on women living with, at risk of or affected by HIV in conflict and post-conflict situations. These efforts must be linked with efforts to achieve the Sustainable Development Goal on peaceful and inclusive societies.

IV. A pathfinder for United Nations reform

47. Acceleration of the pace of United Nations reform is an utmost priority. We must establish a culture of accountability and strong performance management, with a focus on delivery rather than process and on people rather than bureaucracy. During the 2016 quadrennial comprehensive policy review of operational activities for development of the United Nations system, Member States called for a United Nations development system that was more strategic, integrated, coherent, efficient, accountable and results-oriented.[11]

48. Many of the reforms called for in the quadrennial review are standard practice within UNAIDS. Examples include active coordination of United Nations entities at the global and country level; the leveraging of evidence and strategic information in policy development and programmatic guidance; multisectoral and multi-stakeholder approaches underpinned by the values of human rights, gender equality and sustainability; and transparent governance that engages civil society. UNAIDS also tracks the trajectory of the epidemic and the response, and provides critical support to financing mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, including technical support to the development and implementation of grant programme. Nevertheless, financial support for UNAIDS, which relies entirely on voluntary contributions, has decreased in recent years.

49. The disconnect between the global ambition concerning AIDS and the level of financing for UNAIDS threatens the sustainability of the Joint Programme and efforts to achieve the targets and milestones in the 2016 Political Declaration. In response, the UNAIDS Programme Coordinating Board has tasked a multi-stakeholder global review panel with making recommendations for a sustainable and fit-for-purpose UNAIDS by revising and updating the Joint Programme model. Although the panel's work is not yet complete, there is growing conviction that UNAIDS makes a unique contribution to the global AIDS response, remains particularly relevant during this new era of United Nations reform and should be refined and reinforced to deliver clear results within its areas of comparative advantage.

V. Recommendations

Reinvigorate the fast-track response to end AIDS

50. The time available to fast-track and close key financial and programmatic gaps is growing shorter, making it increasingly difficult to speed up the pace of reductions in new HIV infections and achieve the milestones agreed in the 2016 Political Declaration. A concerted push is needed to close the $7 billion investment gap within the framework of global solidarity and shared responsibility, to take AIDS further out of isolation and to maximize the synergies between efforts to end AIDS and to achieve the Sustainable Development Goals. Efforts to achieve universal health coverage require more integrated services for HIV, tuberculosis, viral hepatitis, sexually transmitted infections, cervical cancer and other

[11] General Assembly resolution 71/243.

non-communicable diseases, drug dependence, food and nutrition support, maternal, child and adolescent health, men's health, mental health and sexual and reproductive health. Greater efforts are required to address the HIV and health needs of people affected by humanitarian emergencies, such as people made vulnerable to HIV infection during natural disasters, conflict and forced migration, and people living with HIV whose treatment may be interrupted within these contexts.

Accelerate international commitments on combination HIV prevention

51. Progress towards the programmatic coverage targets for key prevention interventions is uneven. Member States should respond to the call of UNAIDS for a grand prevention coalition dedicated to stimulating action across the five pillars of combination HIV prevention. This prevention coalition should draw on the successful models of the 90-90-90 initiative and the global plan for eliminating mother-to-child transmission. The agenda of the coalition should include the translation of global commitments on condom availability, voluntary medical male circumcision and PrEP into national targets; the generation of greater domestic investment in prevention programmes that focus on key populations, such as sex workers, people who inject drugs, transgender people, prisoners and men who have sex with men; the provision of the technical support required to systematically close programmatic gaps in fast-track countries; and the establishment of a clear accountability framework that keeps national prevention efforts on target.

Continued scale-up of HIV testing and treatment

52. Key fast-track countries have yet to adopt 2015 guidelines by the World Health Organization that call for the immediate offer of antiretroviral therapy following diagnosis and the use of viral load testing as the preferred approach to monitoring patient response to treatment, and few countries have adopted the most recent WHO guidance on HIV testing. Adoption of the latest evidence-informed approaches to HIV testing and treatment is critical to maintaining momentum towards 90-90-90.

53. A "testing revolution" is needed that prioritizes the right of each and all individuals to know their HIV status, brings HIV testing services closer to the individuals and communities that need them and increases investment in HIV testing services. Immediate steps should be taken by countries for the rapid scale-up of community-based testing models, rapid diagnostic testing, HIV self-testing and partner notification and to massively expand the availability of routine viral load monitoring. To improve programme efficiency and increase the reach of treatment programmes, urgent investments are needed to recruit, train and deploy at least 2 million new community health workers over the next two years, including 1 million in sub-Saharan Africa.

Strengthen efforts to empower women and girls, young people, key populations and people living with HIV

54. Closing gaps in service coverage requires the empowerment of populations that are often left behind: women and girls, young people, key populations and people living with HIV. All national AIDS programmes require a strong community empowerment element and specific efforts to address legal and policy barriers. The UNAIDS global AIDS monitoring system and innovative community-based data

collection should be leveraged by Member States, civil society and women's organizations to strengthen existing national, regional and global mechanisms and improve accountability for the reaching of global commitments on keeping girls in school, economic empowerment, reduction of gender-based violence and delivery of the full range of sexual and reproductive health services. Addressing intersectional discrimination, particularly in health care, is critical to reaching fast-track targets. Young people require additional support to participate as beneficiaries, partners and leaders in the HIV response. Increased gathering and analysis of age- and sex-disaggregated data will help identify challenges and opportunities across the life cycle.

Refine and reinforce the operating model of the Joint United Nations Programme on HIV/AIDS so that it can more effectively support countries to achieve their commitments and remain within the vanguard of United Nations reform

55. Efforts to accelerate the pace of United Nations reform have called for action in areas that are hardwired into UNAIDS: active coordination of United Nations entities, inclusive governance, the leveraging of evidence and strategic information in policy development and programming, and the inspiration of multisectoral and multi-stakeholder approaches underpinned by the values of human rights, gender equality and sustainability. UNAIDS also plays a critical role within the wider AIDS response, providing leadership and strategic direction, monitoring the epidemic and the response and supporting countries in maximizing the use of resources of the Global Fund to Fight AIDS, Tuberculosis and Malaria, domestic investment and other sources of funding. Member States are called upon to support the efforts of UNAIDS to refine and reinforce its Joint Programme model so that it can remain a pathfinder for United Nations reform, lead efforts to take AIDS further out of isolation and support countries to fast-track their AIDS responses.